

General Information for Authorization

Org 1.	508					1	се Туре	2. PHYS		
	т				Client In					
Name 3. CLIENT NAME						Clien	t ID	4. 123456789WA		
Living Arrangements 5. N/A						<u> </u>	rence Auth #	6.		
					Provider I	r				
Requesting		7. 1123456	789			Requ	esting Fax #	8. XXXXXXXXX		
Servicing NPI # 9. 112			1123456789			Name	e	10. SERVICING PROVIDER NAME		
Referring N	VPI#	11. 1123450	6789			Refe	ring Fax#	12. XXXXXXXXXX		
Service Start 13							14. N/A			
	!			Se	rvice Requ	est Info	ormation		•	
Description of service being requested: 15. BOTOX INJECTIONS						16. N	/A	17. N/A		
18. Serial	NEA# N/A					19. N	//A	•		
20. Code Qualifier	21. National Code	22. Mod	L	Inits/Days equested	24. \$ Ame Reques	ount ted		25. Part # 26. Tool (DME Only) or Quad		
C	95873				N/A		N/A		N/A	
P	J0585				N/A			N/A	N/A	
							-			
<u> </u>										
	1	ŀ	1		Medical I	nforma	tion		<u> </u>	
Diagnosis Code 27. ICD-9			Diagnosis name		28.					
Place of service 29. 11										
30. Comm	ents: NOTE	:COULD BI	E POS 1	1 or 22						

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The material in this facsimile transmission is intended only for the use of the individual to who it is addressed and may contain information that is confidential, privileged, and exempt from disclosure under applicable law. <u>HIPAA Compliance</u>: Unless otherwise authorized in writing by the patient, protected health information will only be used to provide treatment, to see insurance payment, or to perform other specific health care operations.

Instructions to fill out the General Information for Authorization form, DSHS 13-835

FIELD	NAME		ACTION ALL FIELDS MUST BE TYPED.				
	Org required	Enter the Number that Matches the Program/Unit for the Request					
1 ,		500 - Din 501 - De 502 - Du 509 - Ec 504 - Ho 506 - Inp 507 - Ju 508 - Me 509 - Me 510 - Me 511 - Ou 513 - Ph 514 - Ag	500 - Division of Alcohol and Substance Abuse (DASA) 501 - Dental 502 - Durable Medical Equipment (DME) 509 - Economic Services Administration (ESA) (DSHS) 504 - Home Health 505 - Hospice 506 - Inpatient Hospital 507 - Juvenile Rehabilitation Administration (JRA) (DSHS) 508 - Medical 509 - Medical Nutrition 510 - Mental Health 511 - Outpt Proc/Diag 513 - Physical Medicine & Rehabilitation (PM & R) 514 - Aging and Disability Services Administration (ADSA) 515 - Transportation 516 - Miscellaneous				
	Service Type required	Enter the	e letter(s) in all CAPS that represe	nt the ser	vice type you are requesting.		
		AA BB BEM BGM	Ambulatory Aids Bath Bench Bath Equipment (misc) Blood Glucose Monitors	OS OTC PAS PDN	Orthopedic Shoes Orthotics PAS		
		BGS BP BS BSS2	Bone Growth Stimulator Breast Pumps Bariatric surgery Bariatric surgery stage 2	Private PHY PL PMR	Duty Nursing Pharmacy Patient Lifts PM and R		
·		C CI CIERP CSC CWN	Commode Cochlear Implants Cochlear Implant Ext Repl Prts Commode/Shower Chair Crowns	PROS PRS PSY PTL PWH	Prosthetics Prone Standers Psychotherapy Partial Power Wheelchair - Home		
2		DASA DEN EN ESA FSFS	DASA Dentures Enteral Nutrition ESA Floor Sitter/Feeder Seat	PWNF PWNF PHYS R RBS			
		HB HEA HH HSPC IPT ITA	Hospital Beds Hearing Aids Home Health Hospice Infusion/Parental Therapy Inpatient admission - ITA	RE RLNS RM S SBS SC	Room equipment Relines Readmission Surgery Specialty Beds/Surfaces Shower chairs		
		JRA LTAC MC MISC MN MWH	JRA LTAC Medication Miscellaneous Medical Nutrition Manual Wheelchair - Home	SCAN SF SGD SSIP T TRN	MRI/PET Scans Standing Frames Speech Generating Device Short Stay (In-Patient) Therapies (PT/OT/ST) Transportation		
		MWNF O ODC ODME OOS OP	Manual Wheelchair - NF Other Orthodontic Other DME Out of State Ostomy Products	TU US V VNSS VOL WDCS	TENS Units Urinary Supplies Vision Vagus nerve stimulator surgery Inpatient admission-Voluntary Wound/decubiti care supplies		

3	Name: Required.	Enter the last name, first name, and middle initial of the patient you are requesting authorization for.
	Client ID: Required.	Enter the client ID = 9 numbers followed by WA.
4		 For Prior Authorization (PA) requests when the client ID is unknown (e.g. client eligibility pending): You will need to contact DSHS at 1-800-562-3022 and the appropriate extension of the Authorization Unit (See contact section for further instructions). A reference PA will be built with a placeholder client ID. If the PA is approved – once the client ID is known – you will need to contact DSHS either by fax or phone with the Client ID. The PA will be updated and you will be able to bill the services approved.
	Living Arrangements	Indicate where your patient resides such as, home, group home, assisted living, skilled
5	LIVERY ATTAINS OF THE LIVERY	nursing facility, etc.
6	Reference Auth #	If requesting a change or extension to an existing authorization, please indicate the number in this field.
7	Requesting NPI #: Required.	The 10 digit numeric number that has been assigned to the requesting provider by CMS.
8	Requesting Fax#	The fax number of the requesting provider.
9	Servicing NPI #: Required.	The 10 digit numeric number that has been assigned to the billing/servicing provider by CMS.
10	Name	The name of the billing/servicing provider.
11	Referring NPI #	The 10 digit numeric number that has been assigned to the referring provider by CMS.
12	Referring Fax #	The fax number of the referring provider.
13	Service Start Date	The date the service is planned to be started if known.
15	Description of service being requested: Required.	A short description of the service you are requesting (examples, manual wheelchair, eyeglasses, hearing aid).
18	Serial/NEA#: Required for all DME repairs.	Enter the serial number of the equipment you are requesting repairs or modifications to or the NEA# to access the x-rays for this request.
20	Code Qualifier: Required.	Enter the letter corresponding to the code from below: T - CDT Proc Code C - CPT Proc Code D - DRG P - HCPCS Proc Code I - ICD-9/10 Proc Code R - Rev Code N - NDC-National Drug Code S - ICD-9/10 Diagnosis Code
21	National Code: Required.	Enter each service code of the item you are requesting authorization that correlates to the Code Qualifier entered.
22	Modifier	When appropriate enter a modifier.
23	# Units/Days Requested: Required.	Enter the number of units or days being requested for items that have a set allowable. (Refer to the program specific <u>Billing Instructions</u> for the appropriate unit/day designation for the service code entered).
24	\$ Amount Requested: Required.	Enter the dollar amount being requested for those service codes that do not have a set allowable. (Refer to the program specific <u>Billing Instructions</u> and <u>fee schedules</u> for assistance) Must be entered in dollars & cents with a decimal (e.g. \$400 should be entered as 400.00.
25	Part # (DME only): Required for all "By Report" codes requested.	Enter the manufacturer part # of the item requested.

26	Tooth or Quad#: Required for dental requests	Enter the tooth or quad number as listed below: QUAD 00 – full mouth 01 – upper arch 02 – lower arch 10 – upper right quadrant 20 – upper left quadrant 30 – lower left quadrant 40 – lower right quadrant Tooth # 1-36, A-T, AS-TS, 51-82 and SN
27	Diagnosis Code	Enter appropriate diagnosis code for condition.
28	Diagnosis name	Short description of the diagnosis.
29	Place of Service	Enter the appropriate two digit place of service code.
30	Comments	Enter any free form information you deem necessary.

Field	Name	Action			
		ALL FIELDS MUST BE TYPED			
	Org required	Enter the Number that Matches the Program/Unit for the Request			
		500 - Division of Alcohol and Substance Abuse (DASA)			
		501 Dental			
		502 Durable Medical Equipment (DME)			
		509 Economic Services Administration (ESA) (DSHS)			
		504 - Home Health			
		505 - Hospice			
		506 - Inpatient Hospital			
1		507 - Juvenile Rehabilitation Administration (JRA) (DSHS)			
		508 - Medical			
		509 Medical Nutrition			
		510 - Mental Health			
		511 - Outpt Proc/Diag			
		513 Physical Medicine & Rehabilitation (PM & R)			
		514 Aging and Disability Services Administration (ADSA)			
		515 Transportation			
		516 - Miscellaneous			
	Service Type required	Enter the letter(s) in all CAPS that represent the service type you are			
		requesting.			
		AA Ambulatory Aids			
		BB Bath Bench			
		BEM Bath Equipment (misc)			
		BGM Blood Glucose Monitors			
		BGS Bone Growth Stimulator			
		BP Breast Pumps			
		BS Bariatric surgery			
		BSS2 Bariatric surgery stage 2			
		G Commode			
		CI Cochlear Implants CIERR Cochlear Implant Fat Real Reta			
2		CIERP Cochlear Implant Ext Repl Prts CSC Commode/Shower Chair			
Z,	·	CWN Crowns			
		DASA DASA			
		DEN Dentures			
		EN Enteral Nutrition			
		ESA ESA			
		FSFS Floor Sitter/Feeder Seat			
		HB Hospital Beds			
		HEA Hearing Aids			
		HH Home Health			
		HSPC Hospice			
		IPT Infusion/Parental Therapy			
		ITA Inpatient admission—ITA			
		JRA JRA			
		LTAC LTAC			

Field	Name	Action	
		MG	Medication
		MISC	Miscellaneous
		MN	Medical Nutrition
		MWH	Manual Wheelchair - Home
		MWNF	Manual-Wheelchair NF
		θ	Other
		ODC	Orthodontic
		ODME	Other DME
		oos	Out of State
		OP	Ostomy-Products
		OS	Orthopedic Shoes
		OTC	Orthotics
		PAS	PAS
		PDN	Private Duty Nursing
		PHY	Pharmacy
		PL	Patient Lifts
		PMR	PM and R
		PROS	Prosthetics
		PRS	Prone Standers
		PSY	Psychotherapy
	•	PTL	Partial .
		PWH	Power Wheelchair Home
	•	PWNF	Power Wheelchair - NF
		PWNF	Power Wheelchair NF
		PHYS	Physician Services
		R	Respiratory
		RBS	Rebases
		RE	Room equipment
		RLNS	Relines
		RM	Rendmission
		S	Surgery
		SBS	Specialty Beds/Surfaces
		SC	Shower chairs
		SCAN	MRI/PET Seans
		SF	Standing Frames
		SGD	Speech Generating Device
		SSIP	Short Stay (In-Patient)
		Ŧ	Therapies (PT/OT/ST)
		TRN	Transportation
		TU	TENS Units
		US	Urinary Supplies
		¥	Vision
		VNSS	Vagus nerve stimulator surgery
		VOL	Inpatient admission-Voluntary
		WDCS	Wound/decubiti care supplies
2	Name: Required.		st name, first name, and middle initial of the patient you
3	<u></u>	are requesting	ng authorization for.
4	Client ID: Required Enter the client ID = 9 numbers followed by WA		
4	-		

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5		assisted living, skilled nursing facility, etc. NOT REQUIRED FOR PHYSICIAN SERVICES
6	Reference Auth #:	If requesting a change or extension to an existing authorization, please indicate the number in this field.
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24	\$ Amount Requested: Required.	NOT REQUIRED FOR PHYSICIAN SERVICES Enter the dollar amount being requested for those service codes that do not have a set allowable. (Refer to the program specific Billing Instructions and fee

Field	Name	Action
		schedules for assistance) Must be entered in dollars & cents with a
		decimal (e.g. \$400 should be entered as 400.00.
25	Part # (DME only): Required for	NOT REQUIRED FOR PHYSICIAN SERVICES Enter the
23	all "By Report" codes requested.	manufacturer part # of the item requested.
	Tooth or Quad#: Required for	NOT REQUIRED FOR PHYSICIAN SERVICES
	dental requests	Enter the tooth or quad number as listed below:
		QUAD
		00 full mouth
5.		01 upper arch
26		02 lower arch
20		10 upper right quadrant
		20 upper left quadrant
		30 lower left quadrant
		40— lower-right quadrant
		Tooth # 1 36, A T, AS TS, 51-82 and SN
27	Diagnosis Code:	Enter appropriate diagnosis code for condition.
28		
20	Place of Service	Enter the appropriate two digit place of service code.
29		Use 11 for office or 22
30	Comments:	Enter any free form information you deem necessary.